MUSCOGEE (CREEK) NATION
CHILDREN AND FAMILY SERVICES

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____ _____ _____
Client's Name | Social Security No. | Date of Birth

AUTHORIZE: **TO RELEASE TO:**

_____ _____
Name of person or agency releasing information | Name of person or agency receiving information

_____ _____
Address | Address

_____ _____
Phone | Phone

Reason for releasing information: _____

PLEASE CHECK INFORMATION REQUIRED

( ) Psychological Testing
( ) Discharge Summary
( ) Health & Drug Record
( ) Consultations
( ) Progress Notes
( ) Lab Work, EKG
( ) Physicians Orders
( ) Treatment Plan
( ) Psychosocial
( ) Other _____

This authorization includes any and all information or opinions regarding my physical condition or any psychological evaluation of me and any treatment rendered thereon to me, and to allow Muscogee (Creek) Nation CFSA to see or copy any records which you may have regarding my condition or treatment. This authorization, also, includes any medical records, which may or may not include alcohol and/or drug abuse treatment within the records.

The information authorized for release may include information which may indicate the presence of a communicable or venereal disease which may include, but is not limited to, diseases such as Hepatitis, Syphilis , Gonorrhea, and the Human Immunodefiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS)

<u>Consent will expire 90 days from the date of authorization</u>

Signature of Client: _____ **Date:** _____

Witnessed by: _____ **Date:** _____

Subscribed and Sworn to me this _____ **day of** _____ **20** _____.

My Commission Expires: _____ _____